Equity and Access Council Glossary of Terms

Accountable Care Organizations (ACOs)
A health provider–led organization designed to manage a patient's full continuum of care and be responsible for the overall costs and quality of care for a defined population. Multiple forms of ACOs are possible, including large integrated delivery systems, physician–hospital organizations, multi–specialty practice groups with or without hospital ownership, independent practice associations and virtual interdependent networks of physician practices.

ACO types cluster into three broad groups: those led by hospitals (Independent Hospital and Hospital Alliance), those led by physician groups (Independent Physician Group, Physician Group Alliance and Expanded Physician Group) and those led by integrated delivery systems (Full Spectrum Integrated).

Organization types include:

Full Spectrum Integrated ACOs
Provide all aspects of healthcare directly to their patients, with a large, integrated delivery network.

Independent Physician Groups ACOs
Are owned by a single physician group and do not contract with other providers for additional services.

Physician Group Alliances ACOs
Similar to Independent Physician Groups ACOs but can be owned by multiple physician groups. They do not contract with other providers for further services.

Expanded Physician Groups ACOs
Only offers outpatient services directly, but they do contract with other providers to offer hospital or advanced care services.

Independent Hospital ACOs
ACOs with a single owner that provides direct inpatient services. Outpatient services can be provided directly by the ACO if the owner is an integrated health system or a physician-hospital organization.

Hospital Alliance ACOs
ACOs with multiple owners with at least one owner directly providing inpatient services. Outpatient services can be provided either directly or by a contracted provider.

Source: Alliance for Health Reform and Leavitt Partners

Cost Benchmark Calculation
Future cost estimation for population of patients attributed to a provider, from which shared savings calculations are determined. This is usually determined in two steps, first by choosing the population you will use to estimate costs and second by risk adjusting the population. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Historical Costs
A method used to determine the cost benchmark that uses past patient experiences of the population attributed to a shared savings program to project future expenses for that population. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Control Group Costs
A method used to determine the cost benchmark that uses a comparator group that *is not* based on the past experiences of the patients in the shared savings program. Control groups can be based on: 1) What is considered to be best practice in the region. 2) The broader regional

provider network, or 3) A comparator group that is deemed to be similar. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Risk adjustment
Risk adjustment helps to determine if a particular population of patients is sicker than another similar group. Risk adjustment is an objective way to determine the illness burden of a group of patients and is generally applied to shared savings cost benchmark estimations to appropriately estimate expected costs. While current risk adjustment methodologies do not typically account for certain demographics (e.g.; poverty, language barriers, etc.) or severity of illness, any adjustment factor could be included if it is believe to impact the intensity of services a patient requires.

Fee for Service (FFS)
A method of paying health care providers a fee for each medical service rendered.

Patient Selection
Patient selection refers to efforts to avoid serving patients who may compromise a provider's measured performance or earned savings. *Source: Equity and Access Council Charter*

Patient Attribution
Method used to assign a patient to a provider in a shared savings model. Attributing patients to providers is an essential component of the ACO model for purposes of performance measurement (both cost and quality) and payment incentives. It is important to note that accountability for assigned patients lies with the ACO, not the individual provider. It should be noted that a combination of attribution methods can be used. For example, there can be assignment based on the plurality of visits used in combination with patient selected attribution. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015 and ACO Toolkit*

Prospective Attribution
When patients are assigned to providers at outset of performance year. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Retrospective Attribution
When patients are assigned to providers at end of performance year. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Plurality of Visits
The attribution methodology that assigns a patient to a provider based on the frequency of their visits across providers. This methodology can be used retrospectively or prospectively. In the retrospective application of this methodology patients are attributed to a provider based where they actually received care during the performance year. In the prospective application of this methodology patients are attributed to a provider based on where they received care in the year prior to the performance year. *Source: PowerPoint Presentation Equity and Access Council Meeting, February 5th, 2015*

Patient Selected
The patient selects their primary care provider who will provide the main source of their care at the point of enrolling in the insurance plan. This assigns all patients within a plan to a provider, even new enrollees without utilization history. *Source: ACO Toolkit and PowerPoint Presentation Equity and Access Council Meeting, January 22nd, 2015*

Population- Based
Process of attributing patients based on geography. *Source: PowerPoint Presentation Equity and Access Council Meeting, January 22nd, 2015*

Pay for Performance (P4P)

A method of paying health care providers differing amounts based on their performance on measures of quality and efficiency. While early P4P programs used quality and access measures to determine incentive awards, current models often include measures of physician practice efficiency, such as use of lower-cost generic pharmaceuticals. Payment incentives can be in the form of bonuses or financial penalties. Pay for performance is typically used in combination with fee for service payments to incentive improvement in quality of care and patient safety.

Source: Alliance for Health Reform, Becker's and E&Y

Performance Measurement
Performance Measurement evaluates the impact on patients' care experience and quality of outcomes on their total health. Key goals of performance measurement are to ensure accountability for the quality of care and to identify and drive improvement in areas of substandard care. *Source: ACO Toolkit*

Population Health
The health of a group of people such as those who live in a geographic region, belong to a worksite, or are members of minority groups. *Source: North Carolina Institute for Public Health*

Shared Savings
A payment strategy that offers incentives to provider entities to reduce health care spending for a defined patient population by offering physicians a percentage of the net savings realized as a result of their efforts. Savings typically are calculated as the difference between actual and expected expenditures and then shared between the payer and physicians.

> **Medicare Shared Saving Program**
> A program established by CMS to facilitate coordination and cooperation among health care professionals so as to improve the quality of care received by Medicare patients while reducing the cost of that care; the model requires FFS payment to physicians and other professionals throughout the course of the program with a potential for shared savings distribution at the end. Participants must be part of an ACO.

Source: The Commonwealth Fund

Triple aim in health care
A framework developed by the Institute for Healthcare Improvement that aims to optimize the U.S. health care system by enhancing the patient experience, improving the health of populations and reducing the per capita cost of health care. *Source: Institute for Healthcare Improvement*

Under Service
Under-service refers to systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value based payment arrangements. *Source: Equity and Access Council Charter*

Value Based Payments
Also known as Value–Based Purchasing, is a form of payment that holds physicians accountable for the cost and quality of care they provide to patients; the overall goal is to reduce inappropriate care and reward physicians, other health care professionals and organizations for delivering value to patients. Pioneer Accountable Care Organizations and the Medicare Shared Savings Programs (MSSP) are two examples of value based payment contracts offered by the Centers for Medicare & Medicaid Services (CMS). *Source: AAFP*